PATIENT INFORMATION FORM AND D.O. FOR HOME GLUCOSE MONITORS & SUPPLIES

Please review the Detailed Written Order for accuracy, make all appropriate corrections, and enter NPI, sign & date.

SECTION 1: PATIENT INFORMATION - *Please Print*

NAME ______________________________ **DOB** ____/____/____

ADDRESS ______________________ **CITY** ______________ **STATE** ______ **ZIP** ________

PHONE ______________________ **GENDER** ☐ MALE ☐ FEMALE

INSURANCE PLAN ______________________ **PLAN ID** ______________

SECTION 2: DOCTOR ORDER

1. **DIAGNOSIS:** ☐ **E11.9** ☐ **E10.9** ☐ **E11.65** ☐ **E10.65** ☐ **O99.810** ☐ **O24.418/O99.810** ☐ **Other:** __________
2. **ORDER LENGTH: LIFETIME**, or, if other, ______________ (specify length in months, weeks or days)
3. **MOST RECENT HbA1c RESULT** __________ **DATE OF TEST:** ____/____/____
4. **LAST DATE DIABETES CONTROL EVALUATED AND CHARTED:** ____/____/____
5. **TREATMENT** with insulin: ☐ Yes ☐ No
6. **TESTING REGIMEN:** ________ time(s) per day.
7. **PLEASE PROVIDE DOCUMENTED REASON FOR THE ORDERED TESTING REGIMEN**

   ☐ Hypertension / High Blood Pressure ☐ Fluctuating Blood Sugar Levels ☐ Adjusting Medication

   ☐ Other: ______________________________
8. **DEVICE TRAINING:** Patient/Caregiver is capable of learning proper operation of Device? ☐ Yes ☐ No
9. **PRODUCT ORDER:** Patient is hereby ordered to receive the following supplies (in accordance with Medicare or insurance guidelines) in connection with the Telcare Blood Glucose Monitoring System.

PLEASE CHECK OFF ITEMS YOU WISH TO ORDER.

☐ **ALL ITEMS LISTED BELOW**

☐ **Home Blood Glucose Monitor** ☐ **Home Weight Scale** ☐ **Home Blood Pressure Monitor**

☐ **Test Strips** (per testing regimen and actual use) ☐ **Lancets** (per testing regimen and actual use)

☐ **Testing Device Control Solution** (per mfg.) ☐ **Spring Powered Lancet Device**

SECTION 3: PHYSICIAN INFORMATION - *Please Print*

DOCTOR ______________________ **PRACTICE NAME** ______________________

ADDRESS ______________________ **City** ______________ **State** ______ **Zip** ________

TEL ______-______-______ **FAX** ______-______-______

EMAIL ______________________ **NPI** ______________

By signing below, I confirm the medical supplies and/or medication indicated herein are medically necessary. I will furnish substantiating medical records upon request. I confirm that I have seen this patient within the last 6 months to evaluate their diabetes control.

DATE ____/____/____ **PHYSICIAN SIGNATURE** ______________________________

MM/DD/YYYY

Stamps NOT accepted

Stamps NOT accepted

When completed, please fax to **(978) 832-1071**. THANK YOU

Telcare Medical Supply | 150 Baker Avenue Extension, Suite 300, Concord, MA 01742 | Phone: 978.610.2230